Preventing Substance Abuse Through Worksite Wellness

Cynthia J. Sieck, M.P.H.
Research Associate
University of Michigan Worker Health Program

What I want to do today is provide a brief description of the University of Michigan Worker Health Program, and a first pass of the results. They are not yet complete, but I will talk a little bit about what we have found so far and what we intend to look at.

This study builds on previous Worker Health Program research looking at cardiovascular disease risk and individual wellness counseling. There are four sites in this study. The first site received a health screening; the second site received screening and health education classes; the third site, screening and health education classes, plus individual proactive counseling sessions; and the fourth site; all of those, and in addition, site-wide activity.

What we found was that the fourth site, with all of the ingredients, showed the greatest reduction in risk; additionally, the two sites with individual counseling showed a much greater reduction in risk than the sites that didn't have individual counseling.

The study had two objectives. The first was to test the hypothesis that proactive individual counseling and follow-up with an employee is a more effective method of health improvement than offering health educational classes alone. The second was to determine the effectiveness of the general wellness approach to substance use prevention.

This study took place in a durable goods manufacturing plant in the Midwest with about 4,000 employees, both hourly and salaried.

We had two groups; the first was essentially a control group. They received the more traditional wellness services of a health assessment, which included health education classes, and a re-screening at the end. Individual counseling groups received the same health

screening, then periodic proactive individual follow-up counseling sessions, followed by re-screening at the end. I will explain what I mean by proactive individual follow-up.

The screening consisted of an individual interview, conducted face to face. It contained questions of quantity and frequency of alcohol use, general health questions, personal family history of cardiovascular disease, and biometric measurements of blood pressure and cholesterol.

At the end of the session, all employees went through a brief counseling session discussing their risks and what they can do about them.

For the traditional services group, we offered health education classes throughout the project. We focused on cardiovascular disease risks like weight and smoking, and good habits like nutrition and exercise. But we also emphasized the relationship of alcohol to all those risk factors. For example, in a weight reduction class, we would talk about the idea that alcohol is essentially empty calories.

The second group received proactive individual counseling and follow-up. I want to provide a brief explanation of what this means. We checked back with people to see if they were still smoking or practicing other bad habits, and we also counseled them in an effort to help them move along the continuum of behavior change. We wanted to help them to understand why they should stop smoking if they haven't, or congratulate them for having stopped if they have. These contacts occurred at least every six months, and more often if the client was undergoing behavior change, or if they had a very high risk factor.

Both groups were mostly male, mostly white, mostly hourly employees, about 44 years of age. We had a significantly smaller number in our re-screening group, because a number of employees either retired from the plant, transferred to another plant, or opted not to participate in the re-screening.

The traditional services group was intended to receive only the health education classes, and the individual counseling group was intended to receive the proactive, individual counseling. However, during the course of this project, the plant in which we were working went through changes that were similar to changes going on throughout the nation. They had speed-ups in the assembly line and mandatory overtime for employees, and we found that this was making employees very reluctant to come into the wellness office, even on their break time. They didn't have enough time to stop into the wellness office before or after work. They just didn't want to be at the plant any longer than they had to.

So we worked with our wellness committee in the plant, which was made up of union members, management and EAP staff, and we decided to take the follow-up counseling out onto the plant floor. This approach worked really well for getting the follow-up group in for follow-up counseling, but it wasn't problem-free. When the non-follow-up group saw their co-workers being released for about 15 minutes, they wanted to get off the line for 15 minutes as well.

Since it was a strongly unionized plant, and we had to do a lot to overcome the workers' initial suspicion and develop a good rapport, we thought that turning those people away could actually be damaging to that rapport. So, we decided that we would counsel employees who requested it, but when we came out onto the floor again in the future, we wouldn't proactively reach out to them.

In looking at the participation patterns for the traditional services group, we found that only 7 percent of the group took part in the health education classes that were offered throughout the life of the project. However, we also found that 56 percent of the workers in this group sought out the services of the wellness counselors who appeared on the plant floor. We defined "sought out" as having come to a wellness counselor two or more times. Most participants in the study met with a wellness counselor at least once, and a majority met with a wellness counselor two or more times.

We looked at cardiovascular as well as alcohol consumption changes, but in the interest of keeping to my allotted time, I will talk only about the changes in the number of drinks per week. The following statistics apply only to the people who reported drinking at risky levels at our initial screening. In our experimental group (those who received proactive outreach), we saw a decrease of about three drinks per week, while in the traditional services group, we saw a decrease of about two drinks per week.

Now, given that we had sort of a blurring of the lines between the two groups, it's not too surprising that you don't see a bigger difference. So when we look at this, we can also look at it by the number of visits that person had with the wellness counselor. Zero to two follow-up visits, represents a "less than expected" implementation with the experimental group. With the traditional group there are no expected visits.

With the experimental group, we see a fairly consistent decline in the number of drinks per week, regardless of the number of visits. In the traditional services group, the people who essentially had just a screening and one or two visits, we did see decreased levels of drinking for some, though others actually experienced an increase in their drinking levels. In general, the people who visited counselors more often were the ones who showed decreased levels of drinking.

What we think this is showing, is that for the experimental group, when you are constantly reaching out to these people, you can see a consistent decline in the number of drinks. For the traditional group, when you're waiting for them to come to you, you see a decrease among the very eager people, but the majority fall somewhere in the middle. Most people in the traditional services group had about three visits, and we believe that just waiting for them doesn't produce the same kind of changes you would see if you were reaching out to them.

Q I'm troubled, I guess, by the finding about the people who sought wellness counseling versus people who were proactively sought by the counselors and that there were

such startling differences between the two groups in terms of their drinking behavior. How do you interpret that?

A Well, I guess, the difference is there. With the people who received the proactive counseling, there was always someone there, checking back with them, and they were told that someone would be following up with them on a regular basis. With the other group, we were simply waiting for them to come to us. We had about 27 percent of our sample with drinking at risky levels. Most of the people were in that middle category of three to eight visits. We had few people down there at the bottom.